

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0041228</u></p> <p>Facility Name: <u>ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC</u></p> <p>Address: <u>900 ROYAL HEIGHTS ROAD</u> <u>BELLEVILLE</u> <u>62223</u> Number City Zip Code</p> <p>County: <u>ST. CLAIR</u></p> <p>Telephone Number: <u>(618) 235-6133</u> Fax # <u>(618) 235-9860</u></p> <p>IDPA ID Number: <u>371347517</u></p> <p>Date of Initial License for Current Owners: <u>10/1/95</u></p> <p>Type of Ownership:</p> <table> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve N. Lavenda</u> Telephone Number: <u>(847) 236-1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MAKHLOUF SUISSA</u> (Title) <u>PRESIDENT</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>EDWARD N. SLACK, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MAKHLOUF SUISSA</u> (Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u> (Date) _____	(Print Name and Title) <u>EDWARD N. SLACK, C.P.A.</u>	(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
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Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC# 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>234</u>	Skilled (SNF)	<u>234</u>	<u>85,644</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>234</u>	TOTALS	<u>234</u>	<u>85,644</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,173</u>	<u>7</u>	<u>829</u>	<u>4,009</u>	8
9	SNF/PED					9
10	ICF	<u>53,540</u>	<u>1,797</u>	<u>170</u>	<u>55,507</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>56,713</u>	<u>1,804</u>	<u>999</u>	<u>59,516</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.49%

D. How many bed-hold days during this year were paid by Public Aid?

2 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/1/95

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 10/1/95NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 21and days of care provided 824Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/00Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABIL # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	Dietary	151,789	24,814	7,568	184,171		184,171		184,171			1
2	Food Purchase		229,369		229,369	(6,405)	222,964	(14,579)	208,385			2
3	Housekeeping	148,396	21,951		170,347		170,347		170,347			3
4	Laundry	53,227	18,603		71,830		71,830		71,830			4
5	Heat and Other Utilities			174,226	174,226		174,226	(8,825)	165,401			5
6	Maintenance	47,897	39,769	121,003	208,669		208,669	(1,950)	206,719			6
7	Other (specify):*											7
8	TOTAL General Services	401,309	334,506	302,797	1,038,612	(6,405)	1,032,207	(25,354)	1,006,853			8
9	B. Health Care and Programs											
9	Medical Director			16,400	16,400		16,400		16,400			9
10	Nursing and Medical Records	1,363,964	43,361	1,540	1,408,865		1,408,865	18,916	1,427,781			10
10a	Therapy											10a
11	Activities	68,132	2,727		70,859		70,859		70,859			11
12	Social Services	106,077		12,195	118,272		118,272		118,272			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							2,370	2,370			15
16	TOTAL Health Care and Programs	1,538,173	46,088	30,135	1,614,396		1,614,396	21,286	1,635,682			16
17	C. General Administration											
17	Administrative	52,597		245,284	297,881		297,881	(107,925)	189,956			17
18	Directors Fees											18
19	Professional Services			107,157	107,157		107,157	2,578	109,735			19
20	Dues, Fees, Subscriptions & Promotions			23,504	23,504		23,504	(1,479)	22,025			20
21	Clerical & General Office Expenses	60,401	41,888	114,654	216,943		216,943	5,457	222,400			21
22	Employee Benefits & Payroll Taxes			364,344	364,344	6,405	370,749		370,749			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,092	1,092		1,092	427	1,519			24
25	Other Admin. Staff Transportation			1,715	1,715		1,715	7,043	8,758			25
26	Insurance-Prop.Liab.Malpractice			157,997	157,997		157,997	(8,786)	149,211			26
27	Other (specify):*							15,392	15,392			27
28	TOTAL General Administration	112,998	41,888	1,015,747	1,170,633	6,405	1,177,038	(87,293)	1,089,745			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,052,480	422,482	1,348,679	3,823,641		3,823,641	(91,361)	3,732,280			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC

0041228

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	6,405	
2	FOOD		6,405

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number **ROYAL HEIGHTS NURSING & REHABILITATION CEN #0041228** Report Period Beginning: **01/01/00** Ending: **12/31/00**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
	Depreciation			26,723	26,723		26,723	113,370	140,093			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,930	46,930		46,930	163,947	210,877			32
33	Real Estate Taxes			87,088	87,088		87,088		87,088			33
34	Rent-Facility & Grounds			428,220	428,220		428,220	(418,116)	10,104			34
35	Rent-Equipment & Vehicles			9,585	9,585		9,585	10,982	20,567			35
36	Other (specify):*											36
37	TOTAL Ownership			598,546	598,546		598,546	(129,817)	468,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,906	67,420	123,326		123,326	(18,440)	104,886			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,466	128,466		128,466		128,466			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		55,906	195,886	251,792		251,792	(18,440)	233,352			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,052,480	478,388	2,143,111	4,673,979		4,673,979	(239,618)	4,434,361			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,896	30		9
10	Interest and Other Investment Income	(1,068)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,317)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,242)	21		24
25	Fund Raising, Advertising and Promotional	(2,083)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(80,429)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (137,313)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(102,305)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (102,305)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (239,618)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line
			Reference
1	Deferred Maintenance	\$ 1,673	6 1
2	Prior Period - Therapy	(18,440)	39 2
3	Prior Period - Medical Supplies	(1,521)	10 3
4	Prior Period - Food	(14,509)	2 4
5	Prior Period - Insurance	(9,990)	26 5
6	Prior Period - Electric	(8,825)	5 6
7	Capitalized Repairs & Maintenance	(3,623)	6 7
8	Bank Charges	(1,990)	21 8
9	Non-Allowable Legal Fees	(4,241)	19 9
10	Theft Loss	(17,140)	21 10
11	Missing Legal Invoices	(1,823)	19 11
12			12
13			13
14			14
15			15
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86			86
87			87
88			88
89			89
90	Total	(80,429)	90

Summary A

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Belleville Health		
				Properties	Belleville	Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental	\$ 428,220	Belleville Health Properties		\$	(428,220)	1
2	V	33	Real Estate Taxes	87,089	Belleville Health Properties			(87,089)	2
3	V	30	Depreciation		Belleville Health Properties		96,831	96,831	3
4	V	32	Interest Expense		Belleville Health Properties		164,943	164,943	4
5	V	33	Real Estate Tax Expense		Belleville Health Properties		87,089	87,089	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 515,309			\$ 348,863	\$ * (166,446)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMIN. SAL.-NON OWNER	\$	HEALTHCARE MNGMNT. ASSOC.	100.00%	\$ 31,253	\$	31,253
16	V	19 PROFESSIONAL FEES		HEALTHCARE MNGMNT. ASSOC.	100.00%	8,642		8,642
17	V	20 DUES, SUBSCRIPTIONS		HEALTHCARE MNGMNT. ASSOC.	100.00%	604		604
18	V	21 CLERICAL & GENERAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	58,483		58,483
19	V	24 SEMINAR		HEALTHCARE MNGMNT. ASSOC.	100.00%	427		427
20	V	25 TRAVEL		HEALTHCARE MNGMNT. ASSOC.	100.00%	7,043		7,043
21	V	26 INSURANCE		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,204		1,204
22	V	27 EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	8,490		8,490
23	V	30 DEPRECIATION		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,643		1,643
24	V	34 OFFICE SPACE		HEALTHCARE MNGMNT. ASSOC.	100.00%	10,104		10,104
25	V	32 INTEREST		HEALTHCARE MNGMNT. ASSOC.	100.00%	72		72
26	V	35 EQUIPMENT RENTAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	10,982		10,982
27	V	10 NURSING SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	20,437		20,437
28	V	15 EMP. BEN. - HEALTH CARE		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,370		2,370
29	V	21 CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	34,663		34,663
30	V	27 EMP. BEN. GEN. & ADMIN.		HEALTHCARE MNGMNT. ASSOC.	100.00%	4,077		4,077
31	V							31
32	V	17 ADMIN. SALARY - M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	6,868		6,868
33	V	17 ADMIN. SALARY - D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	15,238		15,238
34	V	27 EMP. BEN.-M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	959		959
35	V	27 EMP. BEN.-D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,866		1,866
36	V							36
37	V	17 MANAGEMENT FEE	161,284	HEALTHCARE MNGMNT. ASSOC.	100.00%			(161,284)
38	V							38
39	Total		\$ 161,284			\$ 225,425	\$ *	64,141

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC

0041228

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V						\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC

0041228

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V						\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC** # **0041228** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES (continued)

- B.** Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC** # **0041228** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES (continued)

- B.** Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC** # **0041228** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Relative	0.00	See Attached	0.7	.97%	Mgmt. Fees	\$ 38,640	17-3	1
2	Mark Suissa	Owner	Administrative	42.32%	See Attached	9.99	15.37%	Alloc-HCMA	6,868	17-7	2
3	Mark Suissa	Owner	Administrative	42.32%	See Attached	9.99	15.37%	Mgmt. Fees	38,640	17-3	3
4	David Aryeh	Owner	Administrative	4.70%	See Attached	19.35	26.88%	Alloc-HCMA	15,238	17-7	4
5	David Aryeh	Owner	Administrative	4.70%	See Attached	19.35	26.88%	Mgmt. Fees	6,720	17-3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 106,106		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization HEALTHCARE MNGMNT. ASSOC.
 Street Address 1401 S. BRENTWOOD BOULEVARD
 City / State / Zip Code BRENTWOOD, MO. 63144
 Phone Number (314) 963-7570
 Fax Number (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. SAL.-NON OWNER	ILL. & MO. PAT. DAYS	357,313	8	\$ 187,631	\$ 187,631	59,516	\$ 31,253	1
2	19	PROFESSIONAL FEES	ILL. & MO. PAT. DAYS	357,313	8	51,885		59,516	8,642	2
3	20	DUES, SUBSCRIPTIONS	ILL. & MO. PAT. DAYS	357,313	8	3,624		59,516	604	3
4	21	CLERICAL & GENERAL	ILL. & MO. PAT. DAYS	357,313	8	351,114	271,845	59,516	58,483	4
5	24	SEMINAR	ILL. & MO. PAT. DAYS	357,313	8	2,566		59,516	427	5
6	25	TRAVEL	ILL. & MO. PAT. DAYS	357,313	8	42,286		59,516	7,043	6
7	26	INSURANCE	ILL. & MO. PAT. DAYS	357,313	8	7,228		59,516	1,204	7
8	27	EMPLOYEE BENEFITS	ILL. & MO. PAT. DAYS	357,313	8	50,973		59,516	8,490	8
9	30	DEPRECIATION	ILL. & MO. PAT. DAYS	357,313	8	9,866		59,516	1,643	9
10	34	OFFICE SPACE	ILL. & MO. PAT. DAYS	357,313	8	60,660		59,516	10,104	10
11	32	INTEREST	ILL. & MO. PAT. DAYS	357,313	8	432		59,516	72	11
12	35	EQUIPMENT RENTAL	ILL. & MO. PAT. DAYS	357,313	8	65,934		59,516	10,982	12
13	10	NURSING SALARIES	ILLINOIS PAT. DAYS	221,422	5	76,034	76,034	59,516	20,437	13
14	15	EMP. BEN. - HEALTH CARE	ILLINOIS PAT. DAYS	221,422	5	8,817		59,516	2,370	14
15	21	CLERICAL SALARIES	ILLINOIS PAT. DAYS	221,422	5	128,960	128,960	59,516	34,663	15
16	27	EMP. BEN. GEN. & ADMIN.	ILLINOIS PAT. DAYS	221,422	5	15,168		59,516	4,077	16
17										17
18	17	ADMIN. SALARY - M. SUISSA	AVG. HOURS WORKED	60	8	41,231	41,231	10	6,868	18
19	17	ADMIN. SALARY - D. ARYEH	AVG. HOURS WORKED	72	5	56,690	56,690	19	15,238	19
20	27	EMP. BEN.-M. SUISSA	AVG. HOURS WORKED	60	8	5,760		10	959	20
21	27	EMP. BEN.-D. ARYEH	AVG. HOURS WORKED	72	5	6,943		19	1,866	21
22										22
23										23
24										24
25	TOTALS					\$ 1,173,802	\$ 762,391		\$ 225,425	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number	ROYAL HEIGHTS NURSING & REHABIL	# 0041228	Report Period Beginning:	01/01/00	Ending:	12/31/00
--------------------------------------	--	------------------	---------------------------------	-----------------	----------------	-----------------

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Corus Bank		X	Mortgage	\$19,672.00	10/1/95	\$ 2,167,000	\$ 1,932,700		9.00%	\$ 164,943	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Corus Bank		X	Line of Credit				392,436		9.5%	46,930	6	
7												7	
8												8	
9	TOTAL Facility Related				\$19,672.00		\$ 2,167,000	\$ 2,325,136			\$ 211,873	9	
	B. Non-Facility Related*												
10	Supplemental Schedule											10	
11	Interest Income										(1,068)	11	
12	Allocation HMA										72	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (996)	14	
15	TOTALS (line 9+line14)						\$ 2,167,000	\$ 2,325,136			\$ 210,877	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.**

(See instructions.)

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILIT.# 0041228

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
1							\$	\$			\$
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21							\$	\$			\$

Facility Name & ID Number **ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC**# **0041228**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	78,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	80,089	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,089	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	85,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	87,089	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	68,014	8
	1996	67,413	9
	1997	72,409	10
	1998	75,485	11
	1999	80,089	12

Accrual: 80,089 X 1.06% = 85,000

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC

0041228

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:A. Square Feet: 62,378 B. General Construction Type: Exterior Brick Frame Block Number of Stories 2C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1995</u>	<u>\$ 237,505</u>	1
2					2
3	TOTALS			\$ 237,505	3

Facility Name & ID Number **ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC** # **0041228** Report Period Beginning: **01/01/00** Ending: **12/31/00****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	234		1995	1975	\$ 2,172,128	\$ 55,696	31	\$ 70,069	\$ 14,373	\$ 367,862	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOOR LOCKS			1996	894	23	20	45	22	214	9
10	AC REPAIRS			1996	647	17	20	32	15	141	10
11	CAST IRON TUB			1996	3,057	78	20	153	75	676	11
12	WASHER REPAIRS			1996	2,597	67	20	130	63	628	12
13	PAINTING & DECOR			1996	2,266		20	113	113	113	13
14	2ND FLOOR RESTORATIO			1996	1,172	30	20	59	29	280	14
15	DOOR LOCKS			1996	2,131	55	20	107	52	508	15
16	MIXING VALVE			1996	1,880	48	20	94	46	423	16
17	MINI BLINDS			1996	1,429	37	20	71	34	320	17
18	AIR CURTAINS			1996	779	20	20	39	19	172	18
19	MINI BLINDS			1996	2,720	70	20	136	66	669	19
20	DECORATING			1996	4,857	125	20	243	118	1,154	20
21	TILE			1996	1,911	49	20	96	47	472	21
22	MINI BLINDS			1996	896	23	20	45	22	214	22
23	WATER HEATER			1997	1,200	31	20	60	29	240	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				51,406	2,302		1,872	(430)	2,271	33
34	PAGE 12B TOTALS				95,574	6,108		4,781	(1,327)	11,278	34
35	PAGE 12A TOTALS				58,173	1,386		2,908	1,522	9,188	35
36	TOTAL (lines 4 thru 35)				\$ 2,405,717	\$ 66,165		\$ 81,053	\$ 14,888	\$ 396,823	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		NURSE CALL SYSTEM		1997	1,401	36	20	70	34	280	9
10		AIR CONDITIONERS		1997	2,187	56	20	109	53	391	10
11		SIDE BY SIDE BUFFER		1997			20				11
12		REPIPE WATER LINES		1997	892	23	20	45	22	180	12
13		ELECTRICAL SWITCHES		1997	594	15	20	30	15	120	13
14		HEAT/AC REPAIRS		1997	1,547	40	20	77	37	257	14
15		WALKWAY		1997	4,995	128	20	250	122	792	15
16		GAS TANKS		1997	1,927	49	20	96	47	360	16
17		DISPOSAL		1997	943	24	20	47	23	168	17
18		HEATING REPAIRS		1997	5,737	147	20	287	140	1,148	18
19		WASHER REPAIRS		1998	507	13	20	25	12	75	19
20		ROOF TOP HEATING SYS		1998	1,171	30	20	59	29	177	20
21		WATER HEATER		1998	8,226	211	20	411	200	1,233	21
22		HEATING REPAIRS		1998	1,438	37	20	72	35	210	22
23		PIPE REPAIRS		1998	1,281	33	20	64	31	187	23
24		TILE		1998	591	15	20	30	15	85	24
25		FIRST FLOOR REPAIRS		1998	1,500	38	20	75	37	206	25
26		FIRST FLOOR REPAIRS		1998	2,905	74	20	145	71	399	26
27		ASPHALT		1998	7,500	192	20	375	183	1,031	27
28		WASHER REPAIRS		1998	1,413	36	20	71	35	213	28
29		FLOOR TILE		1998	1,345	34	20	67	33	201	29
30		HVAC REPAIRS		1998	2,045	52	20	102	50	306	30
31		A/C SERVICE		1998	1,893	49	20	95	46	261	31
32		NURSE CALL SYSTEM		1998	604	15	20	30	15	85	32
33		WALK IN COOLER REPAIR		1998	647	17	20	32	15	91	33
34		AIR CONDITIONERS		1998	4,028		20	201	201	603	34
35		WASHER REPAIRS		1998	856	22	20	43	21	129	35
36		TOTAL (lines 4 thru 35)			\$ 58,173	\$ 1,386		\$ 2,908	\$ 1,522	\$ 9,188	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		OUTDOOR LIGHT POLES		1998	667	17	20	33	16	72	9
10		REPIPE BOILER ROOM		1998	778	20	20	39	19	104	10
11		SHOWER ROO		1998	13,400	344	20	670	326	1,452	11
12		CLOSET DOORS		1998	918	24	20	46	22	111	12
13		FREEZER REPAIRS		1998	2,500	64	20	125	61	313	13
14		WALK-IN FREEZE		1998	1,598	41	20	80	39	213	14
15		CUBICLE CURTAINS		1998	2,255	58	20	113	55	301	15
16		A/C WALL UNITS		1998	1,205		20	60	60	170	16
17		TILE REPLACEMENT		1998	558	14	20	28	14	72	17
18		A/C UNIT REPAIRS		1998	22,949	4,014	20	1,147	(2,867)	3,059	18
19		MENS SHOWER REPAIRS		1998	1,152	30	20	58	28	155	19
20		POWER MIXING VALVES		1998	986	25	20	49	24	131	20
21		REPIPE BOILER ROOM		1998	1,453	37	20	73	36	195	21
22		A/C UNITS		1998	2,695		20	135	135	405	22
23		A/C UNITS		1998	3,254	569	20	163	(406)	394	23
24		A/C WALL UNITS		1998	1,210		20	61	61	173	24
25		A/C WALL UNITS		1998	1,215		20	61	61	178	25
26		AIR CONDITIONER/HEAT		1998	1,210		20	61	61	173	26
27		A/C UNITS		1998	2,395		20	120	120	350	27
28		BIRCH WOOD DOOR		1999	676	17	20	34	17	54	28
29		SMOKING ROOM		1999	27,116	695	20	1,356	661	2,712	29
30		CUBICLE CURTAINS		1999	1,374	35	20	69	34	138	30
31		BLINDS		1999	818	21	20	41	20	82	31
32		WALLPAPER		1999	608	16	20	30	14	60	32
33		LOBBY WALLPAPER		1999	645	17	20	32	15	56	33
34		BATHROOM WALLPAPER		1999	514	13	20	26	13	43	34
35		WALLPAPER		1999	1,425	37	20	71	34	112	35
36		TOTAL (lines 4 thru 35)			\$ 95,574	\$ 6,108		\$ 4,781	\$ (1,327)	\$ 11,278	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CLOSET DOORS			1999	751	19	20	38	19	73	9
10	NURSE WALLSTATION			1999	930	24	20	47	23	90	10
11	ELECTRICAL CIRCUITS			1999	2,447		20	122	122	173	11
12	LOBBY TILES			1999	4,912	126	20	246	120	328	12
13	INSTALL TILE			1999	1,125	29	20	56	27	75	13
14	A/C UNIT			1999	719	230	20	36	(194)	57	14
15	A/C UNITS			1999	2,540	813	20	127	(686)	180	15
16	A/C UNIT			1999	1,905	610	20	95	(515)	127	16
17	DRAPERIES			1999	916	23	20	46	23	77	17
18	ELECTRICALCIRCUITS			1999	1,530		20	77	77	109	18
19	AUTO DOOR LOCKS			2000	624		20	10	10	10	19
20	AIR CONDITIONER			2000	2,193		20	73	73	73	20
21	WALLPAPER			2000	10,150	141	20	296	155	296	21
22	WALLPAPER			2000	9,432	131	20	275	144	275	22
23	DRAPERIES			2000	11,232	156	20	328	172	328	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 51,406	\$ 2,302		\$ 1,872	\$ (430)	\$ 2,271	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
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21												20
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23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
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17										17
18										18
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23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **ROYAL HEIGHTS NURSING & REHABILITA' # 0041228**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 567,178	\$ 57,188	\$ 58,081	\$ 893		\$ 288,665	37
38	Current Year Purchases	8,684	1,577	692	(885)		692	38
39	Fully Depreciated Assets	960	267	267			960	39
40								40
41	TOTALS	\$ 576,822	\$ 59,032	\$ 59,040	\$ 8		\$ 290,317	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,220,044	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 125,197	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 140,093	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 14,896	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 687,140	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC
0041228
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Royal Heights Nursing & Rehab.	89,642	14,410	10,327	(4,083)	36,411
Belleville Healthcare Properties	468,000	41,135	46,800	5,665	245,700
Health Care Management Associates	9,536	1,643	954	(689)	6,554
TOTALS	567,178	57,188	58,081	893	288,665

LINE 29: CURRENT YEAR

Royal Heights Nursing & Rehab.	8,684	1,577	692	(885)	692
Belleville Healthcare Properties					
Health Care Management Associates					
TOTALS	8,684	1,577	692	(885)	692

LINE 30: FULLY DEPRECIATED

Royal Heights Nursing & Rehab.	960	267	267		960
Belleville Healthcare Properties					
Health Care Management Associates					
TOTALS	960	267	267		960

TOTALS (Should Tie to Totals on Page 13)

Royal Heights Nursing & Rehab.	99,286	16,254	11,286	(4,968)	38,063
Belleville Healthcare Properties	468,000	41,135	46,800	5,665	245,700
Health Care Management Associates	9,536	1,643	954	(689)	6,554
TOTALS	576,822	59,032	59,040	8	290,317

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CE # 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Alloc HMA				10,104			5
6								6
7	TOTAL				\$ 10,104			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO16. Rental Amount for movable equipment: \$ 18,203Description: Copiers \$8759; Tank Rental \$575; Dishmachine \$250; Alloc. HMA \$8619
(Attach a schedule detailing the breakdown of movable equipment)**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Alloc HMA		\$	\$ 2,364	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,364	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Facility Name & ID Number **ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC** # **0041228** Report Period Beginning: **01/01/00** Ending: **12/31/00**
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 24,139	\$		\$ 24,139	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,404			9,404	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			33,877			33,877	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				46,535		46,535	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**	39-2					9,371		9,371	13
14	TOTAL			\$		\$ 67,420	\$ 55,906	\$	123,326	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	3,223
2 Air Fluidized Beds	1,023
3 Oxygen	2,039
4 Lab	3,086
5	
6	
7	
8	
9	
10	

9,371

<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE OF ILLINOIS

Page 17

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CEI# 0041228 Report Period Beginning: 01/01/00 Ending: 12/31/00
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 35,297	\$ 37,767	1
2	Cash-Patient Deposits	(17,747)	(17,747)	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	776,774	776,774	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	154,309	154,309	6
7	Other Prepaid Expenses	24,923	24,923	7
8	Accounts Receivable (owners or related parties)	396,867	398,867	8
9	Other(specify): See supplemental schedule	21,825	21,825	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,392,248	\$ 1,396,718	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,505	13
14	Buildings, at Historical Cost		2,172,128	14
15	Leasehold Improvements, at Historical Cos	179,929	179,929	15
16	Equipment, at Historical Cost	143,080	611,080	16
17	Accumulated Depreciation (book methods)	(104,917)	(791,013)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 218,092	\$ 2,409,629	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,610,340	\$ 3,806,347	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 754,845	\$ 754,845	26
27	Officer's Accounts Payable	45,655	45,655	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	392,436	392,436	29
30	Accrued Salaries Payable	83,603	83,603	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,864	24,864	31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,000	85,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,000	3,000	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,389,403	\$ 1,389,403	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,932,700	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,932,700	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,389,403	\$ 3,322,103	46
47	TOTAL EQUITY (page 18, line 24)	\$ 220,937	\$ #REF!	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,610,340	\$ #REF!	48

*(See instructions.)

STATE OF ILLINOIS

Page 17 SUPP-1

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION C# 0041228

Report Period Beginning: 01/01/00

Ending:

12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

Real Estate Tax Escrow

Amount

21,825

Amount

21,825

OTHER CURRENT LIABILITIES:

Accrued Expenses

Accrued R. E. Tax -

Non Care Property

Amount

Amount

21,825

21,825

OTHER NON CURRENT ASSETS:

Construction In Progress

Utility Deposit

Loan Costs

OTHER NON CURRENT LIABILITIES:

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (365,337)	1
2	Restatements (describe):		2
3	Schedule attached	(3,976)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (369,313)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	378,545	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	211,705	9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 590,250	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 220,937	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number	ROYAL HEIGHTS NURSING & REH/#	0041228	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	(369,313)
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Adjustments:

-

-

-

Capitalized Repair & Maintenance	3,976
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Total adjustments	3,976
-------------------	-------

Balance - Beginning of Year	(365,337)
-----------------------------	-----------

Equity(Deficit) from Page 17 Col 1	220,937
------------------------------------	---------

Related Party

Equity(Deficit)

Income

96861

166446

263,307

Combined Equity - End of Year	484,244
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Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITAT # 0041228 Report Period Beginning: 01/01/00

Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,994,010	1
2	Discounts and Allowances for all Levels	(64,872)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,929,138	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,125	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 63,125	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	19,555	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,781	19
20	Radiology and X-Ray		20
21	Other Medical Services	33,609	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 54,945	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,068	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,068	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	4,248	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,248	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,052,524	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,038,612	31
32	Health Care	1,614,396	32
33	General Administration	1,170,633	33
	B. Capital Expense		
34	Ownership	598,546	34
	C. Ancillary Expense		
35	Special Cost Centers	123,326	35
36	Provider Participation Fee	128,466	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,673,979	40
41	Income before Income Taxes (line 30 minus line 40)**	378,545	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 378,545	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 Vending Commissiions	4,248
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	4,248

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CEN

0041228

Report Period Beginning:

01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,388	1,416	\$ 29,475	\$ 20.82	1
2	Assistant Director of Nursing	1,815	1,852	32,513	17.56	2
3	Registered Nurses	14,804	15,584	250,064	16.05	3
4	Licensed Practical Nurses	29,244	29,539	414,434	14.03	4
5	Nurse Aides & Orderlies	78,004	79,596	600,225	7.54	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,443	1,503	11,572	7.70	9
10	Activity Assistants	7,670	7,748	56,560	7.30	10
11	Social Service Workers	10,586	10,802	106,077	9.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,118	19,709	151,789	7.70	15
16	Dishwashers					16
17	Maintenance Workers	4,983	5,085	47,897	9.42	17
18	Housekeepers	22,512	22,971	148,395	6.46	18
19	Laundry	8,705	8,883	53,227	5.99	19
20	Administrator	2,059	2,101	52,597	25.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,677	7,834	60,401	7.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,326	2,373	37,252	15.70	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	212,334	216,996	\$ 2,052,478 *	\$ 9.46	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	237	\$ 7,569	1-3	35
36	Medical Director	Monthly	16,400	9-3	36
37	Medical Records Consultant	44	1,540	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	187	11,068	12-3	45
46	Other(specify) <u>Psycho-Social</u>	18	1,127	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	486	\$ 37,704		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$ 0		53

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Veronica Judd (01/01/00-10/04/00)	Administrator	0	\$ 39,951
Karen Hollingshead (10/05/00-12/31/00)	Administrator	0	12,646
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 52,597
B. Administrative - Other			
Description			Amount
Home Office/Administrative Expense			\$ 161,284
Management Fees - D. Aryeh			6,720
Management Fees - E. Rothner			38,640
Management Fees - M. Suissa			38,640
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 245,284
C. Professional Services			
Vendor/Payee	Type		Amount
Baird, Kurt, Dobson	Accounting		\$ 27,762
Frost, Ruttenberg & Rothblatt	Accounting		28,727
Personnel Planners	Unemployment Tax Consult.		2,800
Care Computers	Data Processing		2,375
Threshold Data	Data Processing		1,500
Kronos	Data Processing		267
AdminaStar	Data Processing		240
Duane Morris & Hecksher	Legal		39,534
Corus Bank	Legal		3,764
Mathis	Legal		189
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 107,158
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 68,464
Unemployment Compensation Insurance			102,978
FICA Taxes			157,015
Employee Health Insurance			11,914
Employee Meals			6,405
Illinois Municipal Retirement Fund (IMRF)*			
Misc. Employee Welfare			23,973
TOTAL (agree to Schedule V, line 22, col.8)			\$ 370,749
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 55)			660
Advertising & Promotion			2,083
Dues & Subscriptions			758
Licenses & Fees			1,989
Classified Advertising			18,014
Allocation HMA			604
Less: Public Relations Expense			()
Non-allowable advertising			(2,083)
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 22,025
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			1,092
Allocation HMA			427
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,519

* Attach copy of IMRF notifications

****See instructions.**

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHABILITATION CI # 0041228Report Period Beginning: 01/01/00

Ending:

12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	6/97	\$ 10,038	3	\$ 1,673	\$ 3,346	\$ 3,346	\$ 1,673	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 10,038		\$ 1,673	\$ 3,346	\$ 3,346	\$ 1,673	\$	\$	\$	\$	\$

Facility Name & ID Number **ROYAL HEIGHTS NURSING & REHABILITATION CENTER, LLC** # **0041228** Report Period Beginning: **01/01/00** Ending: **12/31/00**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 128,466
This amount is to be recorded on line 42 of Schedule V _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 6,405 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw